

State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Quarterly Report
for the period
January 1, 2007 – March 31, 2007

Submitted Via Email on
May 14, 2007

Background and Introduction

The Global Commitment to Health is a Demonstration Initiative operated under a Section 1115(a) waiver granted by the Centers for Medicare and Medicaid Services, within the Department of Health and Human Services.

The state of Vermont is a national leader in making affordable health care coverage available to low-income children and adults. Vermont was among the first states to expand coverage for children and pregnant women, through the implementation in 1989 of the state-funded Dr. Dynasaur program. In 1992, Dr. Dynasaur became part of the state-federal Medicaid program.

When the federal government introduced the State Children's Health Insurance Program (SCHIP) in 1997, Vermont extended coverage to uninsured and under-insured children living in households with incomes below 300 percent of the Federal Poverty Level (FPL).

In 1995, Vermont implemented an 1115(a) waiver program, the Vermont Health Access Plan (VHAP). That program's primary goal was to expand access to comprehensive health care coverage for uninsured adults with household incomes below 150 percent (later raised to 185 percent) of FPL, through enrollment in managed care. VHAP also included a prescription drug benefit for low-income Medicare beneficiaries who did not otherwise qualify for Medicaid. Both waiver populations pay a modest premium on a sliding scale based on household income.

The Global Commitment converts the Office of Vermont Health Access (OVHA), the state's Medicaid organization, to a public Managed Care Organization (MCO). AHS will pay the MCO a lump sum premium payment for the provision of all Medicaid services in the state (with the exception of the Long-Term Care Waiver, managed separately).

The Global Commitment provides the state with the ability to be more flexible in the way it uses its Medicaid resources. Examples of this flexibility include new payment mechanisms (e.g., case rates, capitation, combined funding streams) rather than fee-for-service, to pay for services not traditionally reimbursable through Medicaid (e.g., pediatric psychiatric consultation) and investments in programmatic innovations (e.g., the Vermont Blueprint for Health). The managed care model will also encourage inter-departmental collaboration and consistency across programs.

One of the Terms and Conditions of the Global Commitment Waiver requires the State "to submit progress reports 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas." ***This is the second quarterly report for waiver year two, covering the period from January 1, 2007 to March 31, 2007.***

- a) Events occurring during the quarter, or anticipated to occur in the near future, that affect health care delivery, enrollment, quality of care, and access that are relevant to the Demonstration, the benefit package, and other operational issues.**

Staffing Changes

Effective January 21, 2007, Connie Harrison began work as Financial and Systems Analyst and is now responsible for CMS-64 reporting, among other reporting duties. April 2, 2007, Monica Light began work with AHS as MCO Financial Administrator and in her role will manage the overall fiscal operations for the Global Commitment Demonstration. Effective April 9, 2007, Donald “Rock” Rockwell began work with AHS as Chief Financial Officer and will be responsible for overall oversight of the Agency and thus Global Commitment Fiscal Operations. Connie comes to her position with fifteen years of experience in State government with expertise in data reporting. Both Monica and Rock are new to State employment having come to AHS with extensive backgrounds in healthcare and finance, among other varied career experiences.

MCO Requirements

All MCO work plan activities are progressing as planned. The MCO Grievance and Appeals rules were officially filed with Vermont’s Secretary of State’s Office in the first quarter (this was the first step in the formal legislative review process). A public hearing, required by Vermont’s Administrative Procedures Act, was held in January of 2007 on the proposed rule changes. The purpose of this hearing was to allow for additional feedback on the proposed MCO Grievance and Appeals rules and the necessary changes in corresponding and pre-existing rules across the Agency. The outstanding issues heard during that comment process included opposition to the requirements of exhaustion of MCO appeal prior to fair hearing and disagreements as to whether or not grievances should be allowed to move to fair hearing. Currently the MCO Grievance and Appeals rules are scheduled to be heard by the Vermont Legislature in April of 2007. We expect final changes to be passed and become effective on July 1, 2007. The OVHA and AHS continue to focus on ensuring requirements under 42 CFR sections 438. See Attachment A for updated work plan timelines and list of task completions through March 31, 2007.

Benefit Changes

The Vermont FY07 Budget Act and the Vermont Health Care Affordability Act contain changes regarding cost-sharing amounts, eligibility and benefits including, *VHAP-Employer Sponsored Insurance; Employer Sponsored Insurance Premium Assistance Program; Catamount Health Assistance Program; Revised Premium, Recertification & VHAP eligibility requirements; and a Chronic Care Management Program.*

Vermont submitted a waiver amendment request to CMS on September 11, 2006 to operate those initiatives that require CMS approval within the framework of our approved Global Commitment to Health 1115(a) Demonstration. We will manage the program within the existing financial terms and conditions, so the request is for programmatic approval. This request is an integral piece of a much larger Health Care Reform plan and critical to our state legislative and budgeting process.

A face to face meeting was held in early January of 2007 with CMS central and regional staff in Baltimore. Vermont has since submitted additional clarifications and most recently, written answers to questions sent on behalf of the federal review team.

Financial Administration

Consistent with 42 CFR section 438, in December 2005 Vermont submitted the actuarial certification report prepared by Milliman Consultants and Actuaries, Inc. to CMS for review. Vermont received feedback from CMS that the methodology used by the actuarial firm is acceptable. The contract with Milliman Consultants and Actuaries, Inc. has been extended to develop the SFY2007 rates using the same methodology. The SFY07 actuarial rates as provided by Milliman are still under development as of May 2007.

Health plan financial performance, including capitated revenue expenditures.

The state and CMS collaborated to develop reporting formats and supplemental documentation for the quarterly CMS-64 reports, as well as other financial reports required by the Demonstration's Special Terms and Conditions. We have submitted our CMS-64 reports using the formatting changes provided by CMS. Vermont remains flexible as we work through this process with CMS and reporting formats are finalized.

b) Action plans for addressing any policy and administrative issues identified.

See OVHA/MCO Work Plan (Attachment A)

Vacancies in the AHS-Fiscal Administration Unit have been filled and active and aggressive work is being pursued to complete 2007 Actuarial rates. An RFP for 2008 will be released in the 3rd quarter. The final Actuarial contract award will contain penalty provisions for missed deadlines. In addition, the central office is documenting internal procedures, roles and responsibilities to ensure that rates are consistently delivered in a timely fashion in the future.

During staff transitions this quarter, the AHS-wide cross departmental operations teams has merged its membership with the fiscal team to ensure that fiscal issues that impact policy and program decisions (and vice versa) are clearly communicated.

AHS Deputies and Directors continue to review opportunities for programmatic flexibilities within existing budgeted resources. These include the integration of administrative structures for programs serving the same or similar populations, and opportunities to increase access to services by decreasing administrative burdens created by programs operating, (pre-waiver), under separate AHS administrative and Medicaid reimbursement structures. The projects identified to date and their current status is included in the chart below.

Project Title	Proposal in brief	Status
<i>Early Childhood “3 programs into 1” Project & Supportive Child Care</i>	A streamlined administrative structure and unified plans of care for AHS programs delivering early childhood services.	Pilots scheduled to start April 2007
<i>Children’s Personal Care Services</i>	Offering eligible families choice to receive traditional or flexible benefit package	Implementation plan under development
<i>Unified Service Plans</i>	Unifying service plans for individuals who receive high tech, developmental services and personal care services	Procedures updated, approved and implemented.
<i>Jump on Board for Success</i> (MH services for target youth in order to increase stability of jobs, home and health status)	Performance Based Contract Option to replace fee for service billing.	Pilots expected to start July 1, 2007
<i>Runaway and Homeless Youth</i> (MH services for target youth in order to stabilize crisis and health status, reunify families and counsel youth)	Performance based Contract Option to replace fee for service billing.	Under Review

In addition to looking at AHS programming and opportunities under the waiver, this group continues to be responsible for ensuring that necessary changes in internal operations occur related to the OVHA/MCO work plan (Attachment A), IGA commitments and other relevant state and federal regulations.

During this quarter, the Quality Assurance Performance Indicator Committee (QAPI) spent time reviewing the Federal and State Quality Assessment and Performance Improvement Standards, prioritizing current AHS-wide Performance Measures and reviewing possible HEDIS and CAHPS performance measures for Medicaid plans, and finalizing an agency-wide inventory of Performance Improvement Projects. The QAPI committee has spent much of this quarter determining how and where the Standards found in the CFR and outlined in the AHS-OVHA Intergovernmental Agreement (IGA) pertain to Vermont’s public MCO. The AHS Quality Improvement Manager developed a template to help QAPI committee members become familiar with key points under the Access standards as well as inventory compliance activities associated with each applicable standard. Second, Results of the agency-wide inventory of performance measures were presented to the Global Commitment Cross-Departmental Operations Committee. During the meeting, committee members were able to identify and prioritize five focus areas to be considered when selecting agency-wide measures: employment, social connectedness, access/service availability, utilization (medical, dental and behavioral health), and customer satisfaction. Third, an agency wide -wide inventory of consumer feedback activities was completed. In a related activity, a cross-walk of primary AHS, Department/Division, and MCO experience of care surveys was conducted. Fourth, time was spent inventorying the performance

measures proposed in the Vermont Blueprint for Health and the Care Coordination/Chronic Case Management Program. In addition, performance measures required by CMS regarding provider profiling were also investigated. The purpose of this activity is to generate a list of HEDIS/CAHPS and AHS performance measures to be included in the Quality Strategy that are informed by ongoing State and Federal Quality Improvement efforts. Finally, during this quarter, an agency-wide inventory of Performance Improvement projects was completed. Current projects were then cross-walked with the ten steps outlined in the CMS sponsored protocol for conducting performance improvement projects. This information will be shared with the QAPI committee and 2-3 projects will be recommended for inclusion in the Quality Strategy.

State efforts related to the collection and verification of encounter data.

The OVHA has assembled the Program Integrity Unit combining the Data Team and the Surveillance and Utilization Review System (SURS) Team in order to bring together the data mining expertise to the existing SURS Team. The OVHA has recently added two auditors to the team that have hospital and physician billing background along with auditing experience. One auditor is certified in hospital coding and the other in physician coding.

The vendor for the Chronic Care Management Intervention Services and the Health Risk Assessment administration has been selected and contract negotiation has begun. The state is working with University of Massachusetts, Center for Health Policy Research on the beneficiary selection, evaluation and reporting.

c) Enrollment data, member month data and budget neutrality monitoring tables

No change has occurred this quarter. The state and CMS currently are collaborating with regard to development of budget neutrality monitoring formats. Enrollment and member month data are in section d) below.

d) Demonstration program average monthly enrollment for each of the following eligibility groups:¹

- a. Mandatory State Plan Adults**
- b. Mandatory State Plan Children**
- c. Optional State Plan Adults**
- d. Optional State Plan Children**
- e. VHAP Expansion Adults**
- f. Pharmacy Program Beneficiaries (non-Duals)**
- g. Other Waiver Expansion Adults**

¹ Note: CMS and AHS have agreed that the eligibility groups should be reported as identified in the table rather than in the initial Special Terms and Conditions.

Population	Age Limit	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07
Optional	Under 21	41,180	40,685	40,256	40,327	40,529	40,417
Optional	21 and Over	16,974	16,691	16,464	17,002	16,893	16,827
Mandatory	Thru 18	15,078	15,140	15,112	15,279	15,296	15,257
Mandatory	Over 18	23,981	23,954	23,963	24,130	24,154	24,178
VHAP/Underinsured	Thru 18	1,550	1,552	1,523	1,556	1,469	1,509
VHAP/Underinsured	Over 18	22,196	22,124	21,958	21,498	22,093	22,264
Pharmacy							
Only/HVP	All	22,030	22,160	22,378	22,374	22,462	22,498
SCHIP	All	3,283	3,301	3,240	3,202	2,874	2,817
TOTAL		146,272	145,607	144,894	145,368	145,770	145,767

e) State's progress toward the Demonstration goals.

External Quality Review:

During this quarter, the External Quality Review Organization (EQRO) grant agreement was formally transferred from the Office of Vermont Health Access (OVHA) to the Agency of Human Services (AHS) and the new AHS EQRO contract manager took responsibility. Also during this quarter, the EQRO submitted their annual technical report to AHS for review. This report, in turn, was disseminated to the Division of Mental Health (DMH), OVHA, and CMS. In addition, a quarterly update meeting was held with the EQRO to ensure that grant agreement deliverables remain on track. Finally, the AHS Quality Improvement Manager spent time during this quarter developing a Request for Proposal (RFP) for the new EQRO contract. The RFP is scheduled to be issued on June 1, 2007. Considerable discussion took place this quarter re: optional EQRO activities that might be included in the new RFP to accurately address the needs of the recently formed public MCO. The new EQRO contract manager also spent time during this quarter reviewing previous EQRO contracts with the intention of incorporating past recommendations into the RFP.

f) State's evaluation activities.

During this quarter, the evaluation plan was further revised. The evaluation is designed to not only address the long-term impact of the demonstration, but to provide short-term quantitative data on the progress of the demonstration on an ongoing basis. Since an assessment of the quality of care received by enrollees in the demonstration is one component of the evaluation plan, it will not be finalized until the performance measures identified to assess the quality of care in the Quality Strategy are recommended by the QAPI Committee. Once completed, the revised evaluation plan will be reviewed by AHS and OVHA leadership and a final proposal forwarded to CMS.

ATTACHMENT A

MCO WORKPLAN
UPDATED 03/31/2007

MCO Work Plan (revised 12/31/06)		
AREA/ DESCRIPTION	TASKS	TIMELINE
MEMBER SERVICES		
Interpreter Services		
Oral interpreter services must be provided free of charge to non-English speaking enrollees who request assistance. [438.10(c)(4)]	Arrange for vendor to provide services as needed	Completed
Provider Directory		
A directory must be compiled and maintained. The directory must list the name, location and telephone numbers for all primary care and specialist providers and hospitals participating in the Medicaid program. The directory must also identify any languages other than English spoken by the provider and must include an indicator to identify those who are accepting new patients. [438.10(e)(2)(ii)(D)]	Develop web-based directory with ability to search by address, provider type, etc.	Completed:
	Survey providers on language capacity and open panel issues	Completed
	Develop process for periodic updates (web-based format allows for immediate updates).	Completed
Notification of Terminating Providers		
OVHA must notify an enrollee whose PCP terminates their participation in Medicaid within 15 days of the provider's notice to the state. Enrollees who are regularly seeing a provider who is not their PCP must also be similarly noticed. [438.10(f)(5)]	Develop process for identification of terminating providers	Completed
	Draft notice to enrollees	Completed
	Identify process for determining which enrollees have been "regularly treated" by any terminating provider	Completed
	Print and mail notices within 15 days to affected enrollees	Completed
Enrollee Handbook		
Develop and maintain a current enrollee handbook which covers how to access care, enrollee rights and responsibilities, procedures for obtaining benefits, what to do in a medical emergency and how to file a grievance or appeal. Handbooks must be distributed to new enrollees within 45 days of enrollment. Handbooks must be available in languages other than English if five (5) percent or more of Demonstration enrollees speak that language. [438.10]	Assess need for languages other than English (documentation for CMS)	Completed for PCP and CRT enrollees
	Draft handbook	AHS-wide work group established and meeting for all other enrollees
	Disseminate for input, finalize based on comments received	
	Print a supply for initial distribution	
	Develop and execute handbook distribution process on an ongoing basis	Target date for completion: Spring 2007 (on schedule)
	Post handbook on website	
Advance Directives		
OVHA must prepare and make available information on Advance Directives. [438.6(h)(2)(i)]	Identify materials related to new 2005 state statute regarding Advance Directives	Completed: Link to new statewide information on EDS and OVHA web-page; Providers notified, also sent to enrollees on request.
	Obtain a supply of forms for distribution upon request	
	Post information on website	
	Draft informational notice on Advance Directives and distribute for posting in physicians' offices (EDS Newsletter)	

Member Helpline		
<i>OVHA must maintain a toll-free member hotline during normal business hours to answer enrollee inquiries and to accept verbal grievances or appeals. [438.406(a)(1)]</i>		Completed
GRIEVANCES & APPEALS		
Notice of Adverse Action		
<i>OVHA must provide a written Notice of Adverse Action to each enrollee and their requesting provider of any decision to deny a services authorization request or to authorize a service in an amount, duration or scope that is less than requested. The notice must be sent within 14 days of the receipt of the request for services, unless that timeframe might, in the opinion of the requesting provider, seriously jeopardize the enrollee's health. In the latter event, the notice must be sent within three (3) business days of the request. [438.210]</i>	Develop one Agency Policy for all GC enrollees	New policy drafted; finalized and approved by CMS
	Change administrative rules to reflect new policy	Rulemaking not initiated; alternative process under consideration
	Draft notice to include appeal rights, information on the continuation of benefits, and how to request an expedited appeal	In process: new policy implemented by July 1, 2007
	Develop policies and procedures for processing requests	
	Design notice inserts that describe the various reasons for the denial or reduction in services (e.g., not medically necessary, not a covered service, etc)	
Acknowledgement of Appeal		
<i>Grievances and appeals must be acknowledged in writing (typical standard is within five business days).</i>	Develop notices	In process: new policy implemented by July 1, 2007
	Develop policies and procedures for ensuring notices are sent timely	
	Develop process and assign staff to assist enrollees in filing grievances and appeals	
	Assign staff to receive, date stamp and log in all grievances and appeals	
Resolution of Grievances and Appeals		
<i>OVHA must have a formal process for resolving all grievances and appeals. Providers must be permitted to file grievances or appeals on behalf of their patients if so requested. The following definitions apply: An Action means – 1) The denial or limited authorization of a requested service, including the type or level of services; 2) The reduction, suspension or termination of a previously authorized service; 3) The denial, in whole or in part, of payment for a service; 4) The failure to provide services in a timely manner (as defined by the state); 5) The failure of the public MCO to act within prescribed timeframes. An Appeal means – Any request for a review of an action. A Grievance is – An expression of dissatisfaction with any matter other than an action (e.g., quality</i>	Develop policies and procedures for the receipt, acknowledgement and resolution of grievances and appeals	In process: new policy implemented by July 1, 2007
	Develop a system for logging and tracking grievances and appeals (type, days to resolution, outcome)	
	Develop a system for automated reporting on grievances and appeals	
	Assign staff to process all grievances and appeals	
	Design resolution notices	

of care) [438.400(b)]. Resolution Timeframes: Standard Grievance – 45 days from date of receipt ([438.408(b)(1)] =90days); Standard Appeal – 45 days from date of receipt [438.408(b)(2)]; Expedited Appeal – Three (3) business days from date of receipt [438.408(b)(3)]		
Fair Hearings		
OVHA must ensure that enrollees have the right to request a fair hearing within no less than 20 days or more than 90 days from the date of the notice of resolution of the grievance or appeal. [438.408(f)]. AHS, as the oversight entity, must ensure that the fair hearing is conducted in accordance with all applicable state and federal regulations including timeframes for the conduct of the hearing and the enrollee's due process rights.	Develop policies and procedures for coordinating between the Grievance and Appeals process and the state Fair Hearing process	In process: new policy implemented by July 1, 2007
	Develop a system for notifying enrollees at the time of the resolution of their grievance or appeal of their right to a fair hearing	
	Develop reporting system to track number, types, timeliness and resolution of fair hearings	
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI)		
QAPI Plan		
AHS must develop a strategy and plan which incorporates procedures that: 1) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees, including those with special health care needs [438.204(b)(1)]; 2) Identify the race, ethnicity and primary language spoken by each Demonstration enrollee [438.204(b)(2)]; 3) Provide for an annual, external independent review of the quality outcomes and timeliness of, and access to, the covered services under the Demonstration [438.204(d)]	1) Develop inventory of all QA/QI activities currently underway within OVHA and sub-contracted departments; Develop workgroup to identify new priorities;	Completed 3 rd Quarter FFY07
	2) Summarize into comprehensive QAPI Plan for CMS review	
	3) Ensure that information is available in ACCESS eligibly system	December, 2007
	4) Expand EQRO focus beyond CRT program	Completed
Source of Primary Care		
OVHA must ensure that each Demonstration enrollee has an ongoing source of primary care. [438.208(b)(1)] It must further implement mechanisms to identify persons with special health care needs. [438.208(b)(4)(c)] The quality strategy must specify these mechanisms. [438.208(b)(4)(c)(i)]	Identification of beneficiaries not already participating through PCPLus	In process
	Develop policies and procedures for the selection of a PCP by each Demonstration enrollee	Completed for current PCPlus
	Design information system capacity to capture the PCP information for each enrollee	Completed
	Develop a mechanism for tracking PCP caseload	Completed
Practice Guidelines		
OVHA must adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field, and which are adopted in consultation with contracting health care	Establish a medical advisory task force of contracting professionals to provide consultation on the guidelines to be adopted for physical health issues	Completed
	Select key areas where guidelines are to be developed	Completed

professionals. [438.236(b)]	Research evidence-based guidelines and protocols for each of the key areas	Completed
	Adopt the appropriate guidelines after consultation with the task force	Completed for existing guidelines; on-going identification of new national practice guidelines
	Distribute guidelines to appropriate network providers	Completed
Measuring Performance Improvement		
AHS must operate its QAPI program on an ongoing basis and conduct performance improvement projects designed to achieve, through ongoing measurement and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Procedures must be in place to collect and use performance measurement data and to detect both under- and over-utilization of services. Mechanisms must also be in place to assess the quality and appropriateness of care furnished to enrollees with special health care needs. [438.240(a), (b), (c), & (d)]	Develop inventory of all QA/QI activities currently underway within OVHA and sub-contracted departments;	Completed
	Develop workgroup to identify new priorities;	Completed
	Summarize into comprehensive QAPI Plan for CMS review	3 rd Quarter FFY07
PROGRAM INTEGRITY		
Actuarial Certification of Capitation Rates		
AHS must provide CMS with an actuarial certification of the capitation rates that will be used as the basis of payment of Medicaid funds to the health plan. The rates must be certified by an actuary who meets the standards established by the American Academy of Actuaries. [438.6(c)(4)(i)]	Develop database for actuaries	In process for Year 2 rates
	Establish capitation rates by MEG	
	Obtain written certification from qualified actuary	
	Submit rates to CMS	
Compliance Plan		
OVHA must also have administrative and management arrangements and/or procedures, including a mandatory compliance plan, that is designed to guard against fraud and abuse. This includes written policies, procedures and standards of conduct. A compliance officer must be designated and a compliance committee formed that is accountable to senior management. An effective training and education program must be developed and implemented for the compliance officer and other VHAP employees. [438.608(a) &(b)]	Appoint compliance officer	In substantial compliance with major expansion of activities planned
	Develop written compliance plan	
	Develop policies and procedures for program integrity	
	Develop written standards of conduct	
	Design staff training program	
	Conduct staff training	
MONITORING		
Utilization		
OVHA must monitor the program to identify potential areas of over- and under-utilization. Where such over- or under-	Develop an overall utilization management plan for the Demonstration	Completed with ongoing activities through new Program Integrity

utilization is identified, OVHA shall develop a Corrective Action Plan (CAP) for review by the AHS. [438.240(b)(3)]	Identify key areas for monitoring (e.g., inpatient days, emergency visits, etc)	Unit and FADS
	Establish thresholds for evaluating potentially inappropriately high or low levels of utilization by MEG	
Provider and Enrollee Characteristics		
OVHA's health information system must track certain characteristics of its network providers and enrollees (e.g., enrollees with special health care needs; providers with accommodations for the disabled in their offices) [438.242]	Identify outstanding issues in ACCESS and/other systems related to capturing required enrollee characteristics	Completed
	Ensure that Provider survey captures required information and is in on-line directory	
Enrollee Rights		
Establish policies and procedures on enrollee rights consistent with the requirements of Part 438.100 of 42 CFR.	Expand existing PCP and CRT policies and procedures	Completed for PCP and CRT enrollees; available through enrollee handbook for all enrollees by September, 2007
Encounter Data Validation		
OVHA must put in place a process for validating encounter data and for reporting information on encounters/ claims by category of service. [438.242]	Expand existing processes to include sub-contracted departments.	Completed
	Implement new Fraud and Abuse Detection Decision Support System (FADS)	
ENROLLEE ACCESS & PROVIDER NETWORK		
Availability of Services		
OVHA must ensure that an adequate network of providers to provide access to all covered services is under contract to the state. This includes an assessment of geographic location of providers, considering distance and travel time, the means of transportation ordinarily used by Medicaid enrollees and whether the location provides for physical access for enrollees with disabilities. The assessment must also consider the number of network providers who are NOT accepting new Medicaid patients. OVHA must also ensure that network providers offer hours of operation that are no less than those offered to other patients. OVHA must also subcontract with other selected AHS departments that will provide services to Demonstration enrollees. [438.206]	Conduct geo-access analysis of current network	September 2006 and on-going
	Identify any existing gaps	
	Recruit additional providers as needed	
	Develop process and procedures for provider site visits if warranted	
	Develop ongoing monitoring plan for the provider network	Survey completed; information available in on-line provider directory
	Design process for collecting info on providers with closed panels (no new patients accepted) and those with access/accommodations for the physically disabled	
	Develop contracts (IGAs) with other departments	Completed.
CMS REPORTING		
General Financial Requirements		
AHS/OVHA shall comply with all general financial requirements under Title XIX. AHS must maintain financial records, including the following: 1) Monthly comparisons of projected vs actual expenditures; 2) Monthly report of OVHA revenues and expenses for Demonstration program; 3) Monthly comparisons of projected vs actual caseload, 4) Quarterly analysis of expenditures by service type; 5) Monthly	Document any modifications to current report formats that will be required	On-going
	Assign staff responsible for the production and submission of the required reports	Completed

<i>financial statements; 6) All reports and data necessary to support waiver reporting requirements [IGA 2.12.2]</i>		
Budget Neutrality Reporting		
<i>For the purpose of monitoring budget neutrality, within 60 days after the end of each quarter, the state shall provide to CMS a report identifying actual expenditures under the Demonstration. [STC pg. 20]</i>	Obtain report format from CMS	Still under discussion
	Make any necessary changes to reporting processes and procedures to accommodate the CMS-specified report formats	Still under discussion
	Assign staff responsible for the production of the reports	Completed
	Develop policies and procedures for the development of corrective action plans if actual expenditures exceed the levels permissible under the Demonstration STCs (by year)	Under development

